Refer to: Comfort A: Geriatrics—The missing discipline? (Commentary). West J Med 128:257-259, Mar 1978

Commentary

Geriatrics—The Missing Discipline?

ALEX COMFORT, MB, BCh, DSc, *Santa Barbara, California*

IT WAS AN AMERICAN, Nascher, who first applied the term geriatrics to the medicine of old age. From the pioneer work of Warren, Sheldon and Ferguson Anderson in Britain and Doberauer in Austria, European geriatric medicine has undergone a remarkable florescence. By a curious accident of medical history, it is now the one major medical resource unavailable to the generality of American patients. Pockets of geriatric training exist in the Veterans Administration and some of the great Jewish hospitals, where the old are a traditional concern, but its absence from medical school instruction nationwide is one of the features of American medical education that most surprises an immigrant European doctor, if only on grounds of demography.

Geriatrics in Europe exists as a specialty, with ten university chairs in Britain alone. Some such infrastructure is needed to maintain consultation and research. At the same time, geriatrics is seen as part of the equipment of general internists and primary care physicians who are the linchpins of European health care delivery; a recent planning report in Britain recommends that general physicians with a special interest in geriatrics, rather than specialists who see only the old, should take charge of the geriatric unit in every major hospital, to avoid compartmentalization of medicine.[1] It may be this avoidance of one more subdivision which American deans of medical schools have in mind when they say that geriatrics is not a specialty. If, however, they mean that it does not have to be learned, and that symptomatology, dosages, drug responses and therapeutic options learned from standard internal medicine, which is in fact the medicine of young and middle-aged adults, can be summarily applied to persons over the age of 65 or 70, they are quite simply wrong. It used to be said that "any good doctor can treat a sick child." Pediatrics and geriatrics can both, of course, be learned by trial and error, but we attempt to limit this process by prior instruction.

The author is Adjunct Professor, Department of Psychiatry, University of Southern California School of Medicine, Los Angeles, and formerly Head, Medical Research Council, Research Group on Aging, University College, London.

Reprint requests to: Dr. Alex Comfort, 683 Oak Grove Drive, Santa Barbara, CA 93108.

Neglect of Geriatrics

Much of the neglect of geriatrics arises from unspoken "agism"—the old are naturally infirm, their infirmity is biologically ordained, their intellect shares in the decline, they are medically uninteresting to active practitioners, and—until Medicare—they were financially unprofitable. Students who formerly required attitudinal treatment against racism now require it against this culture-based folklore. Alter the attitude that sickness and confusion are idiopathic consequences of the passage of time, and expose a student to an experience of the highly dramatic effects of proper diagnosis and treatment, or the simple withdrawal of ill-judged medication, on the clinical features of old age, and both his professional mettle and his human concern will respond if they exist. Geriatricians are in fact more accustomed to dramatic symptomatic cure than pediatricians.

Most of us now in practice realize that age-dependent problems make up much of our office load, and that their preponderance will grow as the proportion of patients over 65 rises to around 17 percent of the population by the year 2000. Courses in geriatric medicine and geriatric psychiatry, when they are held, attract large numbers of experienced physicians who reckon they can use any help they can get. Once the attitudinal change has been made and ill health in old age

is seen to require diagnostic explanation, there is no mystique about geriatrics, though for reading it is necessary to turn to standard European works such as those of Brocklehurst[3] or Hodkinson.[2] Neither the standard textbooks of medicine, nor, incidentally, the information sheets issued by drug manufacturers, recognize the last third of the human life cycle.

Principles of Geriatric Medicine

The principles involved in conversion from adult to geriatric medicine are simple. We teach them to students as Hippocratic aphorisms. Basically they can be stated as follows: No symptomatology is due to the passage of time alone. But the presentation of major disorders with age becomes increasingly nonspecific, so that the alerting clinical features that we have learned to recognize are absent—coronary heart disease, pneumonia, thyrotoxicosis, myxedema, osteomalacia, electrolyte imbalance and many other treatable conditions may present with no symptoms except mental blunting, loss of activity, and feebleness. Most old people are "well" despite minor continuing pathologic conditions, but in the minority—the evidently unwell—diseases are almost always multiple and the search for unitary causation is misplaced. The old do not normally "decline" in intelligence or mental capacity (only in speed of performance), and although chronic brain syndrome may occur, either through multiple infarcts or through the group of diseases which cause cerebral atrophy, most "dementia," especially when its onset is relatively rapid, is symptomatic. The syndrome of senility, composed of feebleness, mental deterioration, loss of mobility and interest, and eventual death, is not a diagnosis, but the equivalent in geriatric medicine of "failure to thrive" in pediatrics.[2] It calls for energetic investigation, with special attention to the medications the patient is receiving, because about a third of such presentations are wholly or largely iatrogenic and induced by doses (for example, sedatives or antihypertensives) that in adult practice would be trifling. Because of this high susceptibility to drugs and the lowering of the therapeutic index, where multiple pathologies exist not all of them can or should be treated. Management accordingly poses an extremely challenging test of clinical judgment; diuretics, sedatives of all kinds (often ordered to suppress the confusion resulting from undiagnosed endocrine or cardiac disease, or infection, or to "treat" the normal pattern of light sleep in older people) and antihypertensives are the drugs most often overused. Any medication that induces microsomal enzymes can also induce "senile rickets" with its attendant weakness. Watch must also be kept for long-term, unreviewed medication and the borrowing of drugs from neighbors, as well as use of over-the-counter remedies of many kinds, and alcohol. In every case presenting as senility the review and usually the suspension of medication is an initial diagnostic, and not infrequently a curative, step.

Old people do not become crazy because they are old. They have the psychiatric disorders common to humans, plus two problems peculiar to age: the ease with which mentation is disturbed by pathology or medication, and the negative inputs from society. The commonest "senile" psychiatric disorder is not dementia but unrecognized depression, which can simulate it. Every case of psychiatric disorder in age requires first to be assessed as a medical problem, and every medical case requires some supportive psychotherapy—be it only contact with a doctor who does not inwardly fear and despise the old—to restore self-respect and neutralize the culturally prevalent custom of premature social burial.

Scenario for Geriatrics in America

Old people now are better informed, better educated, and higher in expectation—social, political, sexual, financial and medical—than were their predecessors. Their demands for access to modern geriatrics will have to be reckoned with. To a European, the outlook for geriatric medicine in America is alarming, however, out of self-interest. There is a risk that when political pressure generates the first vestiges of a proper health service, no matter how it is fiscally arranged, the demand for "geriatricians" will suddenly be made actual. Since there will be no trained staff to fill it, it will be met by improvisation, and when the results of this are seen, public pressure will lead to the wholesale "headhunting" of Europe, with serious damage to the geriatric services that have trained personnel for home use.

The solution is to train American geriatricians now, and the initial step is the creation first of a cadre that can teach and then of centers of excellence. The numbers required are small, but they need to be sufficient to establish a full experience of geriatrics as part of the intern curriculum, as is now being done, for example, at the

Long Island Jewish Hospital or the University of North Dakota. In the initial stages exchange fellowships could play a major part, with benefit both to Europe and to America.

Most American physicians are not consciously anti-old, any more than many old-time liberals were consciously anti-black. To get geriatrics off the ground we have to attack the cultural assumptions of humane and professional people; this can be done by instruction, but it is far more cogently done by demonstration. The return to vigor of a few "senile" patients under proper management is a spectacle that the average physician, if he has never seen it, will find profoundly consciousness-raising at a professional level. Geriatrics in Europe has thrived in part because students, knowing that they will not need to waste time functioning as entrepreneurs and tradesmen, can devote their energy to functioning as physicians, and it is to physicians and their self-esteem and expertise that geriatrics presents such a rewarding challenge. It is one that should be in line with the change in the social estimate of medicine and the spirit of self-questioning that I meet among young Americans now in medical school.

REFERENCES

1. Medical care of the elderly—Report of the Working Party of the Royal College of Physicians of London. Lancet 1:1092-1095, 1977

2. Hodkinson HM: Common Symptoms of Disease in the Elderly. Oxford, Blackwell, 1976

3. Brocklehurst JC: Textbook of Geriatric Medicine and Gerontology. Edinburgh and London, Churchill, Livingstone, 1973

Growth of the Eye

THE GLOBE of the eye is approximately fully grown at age three. The eye grows from 16 mm to approximately 23 mm during the first three years. It grows a tenth of 1 percent for the next ten years, so a 3-year-old child has approximately a fully mature eye.

—DAVID HILES, MD, *Pittsburgh*

Extracted from *Audio-Digest Ophthalmology*, Vol. 15, No. 14, in the Audio-Digest Foundation's subscription series of tape-recorded programs. For subscription information: 1577 East Chevy Chase Drive, Glendale, Ca 91206.